

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **5771**

**ENTER MAD 11 1940**

Registration District No. \_\_\_\_\_

Primary Registration District No. **5026**

Registrar's No. \_\_\_\_\_

3

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Atchison  
(b) City or town RURAL FOLK  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community #3 Months (Specify whether)  
years, months or days)

3. (a) PRINT FULL NAME Barbara Ann Brown

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If

7. Birth date of deceased Herb Hospital Shenandoah, Iowa  
Oct (Month) 30 (Day) 1939 (Year)

8. AGE: Years \_\_\_\_\_ Months 3 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Shenandoah, Iowa Maryville, Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER { 12. Name J C Brown

13. Birthplace Missouri

14. Maiden name Dorothy Carmean

15. Birthplace Missouri

(City, town, or county) (State or foreign country)

16. (a) Informant J. C. Brown

(b) Address Hamburg, Iowa

17. (a) Burial (b) Date thereof Feb. 14, 1940

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grange Hall Cemetery

18. (a) Signature of funeral director Westboro, Missouri

(b) Address \_\_\_\_\_

19. (a) Feb. 13 (b) Mary G. Chamberlain

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 12<sup>th</sup>  
year 1940 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from January 5,  
1940, to Feb. 12, 1940  
that I last saw her alive on Feb. 9, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Asphyxia  
Iowa

Due to Aspiration of regurgitated stomach contents

Due to Acute upper respiratory infection

Other conditions Pyelitis (B. Coli)

Major findings: Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature C. H. Flanagan (M. D. or other) \_\_\_\_\_

Address Ladwin, Mo Date signed 2-14-40

Duration

Instant

1 week

5 weeks

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 11,

District File Number 340-247

Date Filed MAR 5 1940

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Scott Tucker

....., Registered Apprentice No.....

working under my personal supervision.

Signed Scott Tucker

Licensed Embalmer No. 2559 2724

P. O. Address Westboro, Missouri

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.